STATE OF MONTANA EMPLOYEE GROUP BENEFITS PLAN
2006 ENROLLMENT/CHANGE FORM

Last Name	First Name	MI	Social Security #
Street or PO Box		Work #	SABHRS Employee ID#
City	State	Zip	Agency Name

☐ **WAIVER OF COVERAGE** – I have been given the opportunity to enroll in the State Employee Benefits Plan and decline participation at this time. I understand that if I decide to participate after my initial 31 day enrollment period, I may enroll myself only in the Core Plan, but my existing dependents can **only** be added to the Medical plan at the time they have a Qualifying Event – explained on the back of this form.

PART 1 – NEW ENROLLMENT/ Re-enrollment after Leave of absence – complete Parts 1, 3 & 4

Employment Date: **Or Return to Work Date:**

Pre-tax Plan*
☐ Elect to Participate ☐ Decline to Participate
*available only to new enrollees or during annual change period

Check Coverage Elected	Medical	Dental	Vision
Myself only	☐	☐	☐
Myself & spouse	☐	☐	☐
Myself & child(ren)	☐	☐	☐
Myself & family	☐	☐	☐
Joint core*	☐	☐	N/A

Medical Plan
Indemnity Plan:
☐ Traditional
Managed Care Plans: (check plan's service area in New Employee Booklet)
☐ Peak*
☐ New West*
☐ Blue Choice*
***must list PCP in Part 4**

*Joint Core Partner's Name _____
SS# Agency

NEW ENROLLMENT/RE-ENROLLMENT AFTER LEAVE OF ABSENCE

You must complete and return form to agency Payroll personnel within 31 days—of first day of employment/return.

PART 2 – CHANGES TO DEPENDENT COVERAGE – Complete Parts 2, 3 & 4

To add or delete dependents, (1) check the Qualifying Event allowing the change & (2) indicate the date of the event below:

Event allowing addition (event must have been within last 63 days)**:**
☐ Marriage ☐ Birth of child ☐ Court-ordered custody/Support/Legal Guardianship ☐ Adoption/Pre-adoptive placement ☐ Declaration of a Domestic Partner Relationship (requires Declaration of Domestic Partner form)
(Attach copy of legal documentation – marriage/birth certificate, court order, adoption/pre-adoption papers.) (If dependent has or had other coverage within last 63 days, attach Certificate of Prior Coverage.)
☐ Dependent lost eligibility for other group medical coverage due to, specify: _____ OR
☐ there was a major adverse change in other coverage. *(Attach documentation of change from dependent's plan/employer.)*
The Date of Event is the last date of the other coverage or the change in coverage. (Attach Certificate of Prior Coverage.)
☐ Dependent transferring to you from another State Plan member (specify from whom).
Name: _____ SS# _____ Agency: _____

Event requiring or allowing deletion: (*Contact Employee Benefits within 60 days for COBRA continuation information)
☐ Death of spouse/child* ☐ Divorce*/Legal separation*/Change in support order/Dissolution of Domestic Partnership*
☐ Other loss of Child's dependent status* due to, specify:_____.
☐ Cancel Joint Core – Complete section to the left indicating your Joint Core Partner's Name, Agency, & SSN.
☐ Spouse/Child became eligible for other employer benefits (please list date of event below).
☐ Major change in other coverage. *(Attach documentation of change from dependent's plan/employer.)*
Other: *☐ Not related to one of above events – Specify reason: _____ .
Date of Event:

PART 3 – EFFECTIVE DATE (read "Effective Date" section on back and check election below)

NEW HIRE or BIRTH/ADOPTION
(SEE INSTRUCTION ON BACK)
☐ 1st day of full pay period following receipt of form
☐ Date of hire – I agree to self-pay if necessary

Dependent to Employee Status Change

I am transferring to Cert-Holder from dependent under:
Name_____
SS# _____ Agency _____

PART 4 – DEPENDENTS

Circle One	*Circle Coverages*		Name	Sex M/F	Birth Date	Social Security #	If Managed Care Plan – list PCP Primary Care Physician's Name & City
----------	----------	Employee					
Add / Delete	Medical/Dental/Vision	Spouse					
Add / Delete	Medical/Dental/Vision	Child					
Add / Delete	Medical/Dental/Vision	Child					
Add / Delete	Medical/Dental/Vision	Child					

PART 5 – SIGNATURE / CERTIFICATION: I elect the coverage or changes indicated above. By signing below, I certify that: **1)** the above information is correct and my coverage elections are considered an irrevocable agreement for this benefit year; **2)** I agree to pay the premium necessary to effect this coverage and authorize payroll deduction, if applicable; **3)** I understand the 12-month waiting period on pre-existing conditions and know that if I had other coverage prior to State Plan enrollment, I need to provide a Certificate of Prior Coverage – in order to receive credit toward either waiting period; and **4)** I understand I can only enroll dependents in my medical plan during my initial enrollment or with a Qualifying Event, as described on the back of this form.

Signature _____ **Date** _____

ADMINISTRATIVE USE ONLY

Effective Date _____
Assigned by _____
Agency # _____ Loc _____

System Entry Date _____
Entered by _____

Rev. 12/05 *Distribution*: *WHITE – State Personnel Div.* *CANARY – Agency Files* *PINK – Certificate Holder*

INSTRUCTIONS

WAIVER of Coverage/Enrollment – If waiving enrollment in the Employee Group Benefits Plan, please complete the Name/Address section and mark the Waiver of Coverage/Enrollment box, then sign and date the form in Part 5.

NEW ENROLLMENT/RE-ENROLLMENT – If enrolling for coverage, or re-enrolling following approved leave without pay, please: a) complete all applicable sections of Part 1, including the Pre-Tax section (not available to re-enrollees until next annual change period); b) mark the effective date of coverage you select in Part 3, after reading the "EFFECTIVE DATE" section next column; and c) list the names and other information, for all ***dependents**** to be insured, in Part 4.

Re-enrollees - Employees will have a 12-month waiting period for coverage of any pre-existing medical conditions if coverage lapsed for more than 63 days before re-enrollment.

The **Joint Core** provision gives employees, whose spouse also works for the State, medical & dental coverage for dependent child(ren) with only one family deductible, out-of-pocket maximum and may have a lower premium.

CHANGES TO DEPENDENT COVERAGE –To make dependent changes: a) check the ***Qualifying Event**** necessitating the change and provide the date of the event in Part 2; (also provide any indicated documentation such as a divorce decree or, for a major change in other coverage, documentation of benefits and premiums before and after the change); and b) list the names and other information for affected ***dependents**** in Part 4, if applicable.

***Eligible Dependent** is defined in the Employee Benefits Summary Plan Document. It is the responsibility of the employee to only enroll, re-enroll or add dependents that satisfy the definition of eligible dependent and to remove from coverage, any dependents that become ineligible as a result of divorce or some other change of circumstances. Contact your agency insurance personnel immediately when dependents become ineligible for coverage. *The employee will be held responsible for repayment of any claims dollars paid for an ineligible dependent which exceed premiums collected for the ineligible dependent. Also, any excess premiums paid for coverage of a dependent that cease to be eligible cannot be refunded if you are in the Pre-tax Plan.*

EFFECTIVE DATE – Part 3 of this form must be completed to indicate your desired effective date for a new enrollment or births/adoptions where there are options. See effective date options below. ***If neither option is chosen, the enrollee effective date will default to the first day of the pay period following receipt of the form.***

Effective Date for New Enrollment/Re-enrollment:

→ **Date of hire or first day of pay period following receipt of form. Form must be received at the Employee Benefits Bureau within 31 days of hire date. Some premiums may be paid on an after tax basis if you elect date of hire.**

→ **Effective Date Options for Addition of Dependents:**

-The first day of the pay period following receipt of form. Form must be received at the Employee Benefits Bureau within 63 days of qualifying event.

- A newborn child/adoption can have an effective date of the first day of the pay period in which the first 31 days of automatic coverage expires if this form is submitted within the 63 days, and any required premium is paid.

Effective Date for Deletion of Dependents:

→ **1st day of the pay-period following the *Qualifying Event*****

*Divorce, legal separation, and Domestic Partner premiums will be taken through the end of the month in which event occurs. Refunds will not be allowed for late notification.

****Qualifying Event* – For adding Dependents after an employee's *initial 31-day enrollment period*:**

- Events creating new dependent status – marriage, domestic partner declaration, birth of a child, adoption or pre-adoption placement, court-ordered custody, a medical child support order, legal guardianship.
- For existing dependents (who were not initially enrolled because of other group medical coverage), events causing loss of eligibility for the other coverage, such as termination of a spouse's employment, or a major adverse change in the other coverage. *Dependents can also be added to the dental plan each Annual Change Period.*

***Qualifying Event* – For an employee on the Pre-Tax Plan to delete a dependent or dependents from coverage mid year:**

- Events causing loss of dependent status and therefore, eligibility for State employee benefits such as divorce, legal separation, dissolution of a domestic partner relationship, or death of a dependent.
- A change in the employee's employment status (such as leave without pay).
- Changes in dependent's employment or legal status which make them eligible for other group insurance coverage (such as employment of a spouse, marriage of a dependent child, or a change in a child support decree) or a major change in the other insurance coverage, such as a new plan option (documentation required).